JOURNALS

Have editors got their priorities right?

Whistleblower claims they are more worried about being sued for libel than about ensuring research is valid

Journal editors are much more frightened of being sued for libel by academics or drug companies than they are of publishing fraudulent research, the whistleblower Peter Wilmshurst claimed last week.

And he should know. He has spent the last 25 years of his life trying to expose cases of research misconduct (reporting more than 20 doctors to the General Medical Council), and has found it an uphill struggle. His career has suffered and he has received many brickbats and few bouquets.

Dr Wilmshurst, a consultant cardiologist at the Royal Shrewsbury Hospital NHS Trust, was describing his experiences to the annual meeting of HealthWatch, an organisation set up to campaign against health fraud. Television presenter Nick Ross presented him with the organisation's annual award for his courage in challenging misconduct in medical research.

Dr Wilmshurst explained how he knew that journal editors were more worried by libel than dubious research. He said that every time that he submitted an article highlighting research fraud, every word was scrutinised by an army of libel lawyers and the article was frequently rejected. This was in stark contrast to the reception he received when he submitted research articles.

"I have submitted many scientific articles for publication and many had implications for survival of patients, but no journal has ever asked me to prove that I got the results claimed. This might suggest that medical journal editors are more concerned with the reputations of academics and their institutions than the lives of patients.

"The simple truth is that editors are most concerned with money. Journals are never sued for publishing false results no matter how many patients died. In scientific research they can have the best of both worlds. They are absolved from blame if a study is wrong and gain an improved impact rating if the research is an important advance …

"I would like to see whether the policies at journals changed if some were sued by patients harmed by implementation of treatments based on their publications."

Moreover, journals and academic institutions failed to recognise the venality of some researchers, for whom getting their research published was worth a great deal of money. The gains from dishonest research were great "but institutions and journals trust researchers not to fall prey to these."

He offered the following solution. "We need to put in place robust checks on research. I believe that there should be random checks of raw data of work in progress and of submitted work. We know that the use of performance enhancing drugs is common in competitive sports because of enforced drug checks without warning at sporting events and between events.

"If we did not have these checks we might mistakenly conclude that doping was not common in sport. I believe that the checks reduce the dishonesty in sport.

"We need a similar approach to research. The raw data could be demanded at a routine check during a visit to the research institution or when the research is submitted for publication.

"Failure to produce the raw data should be considered the equivalent of failing the inspection and should result in a ban on future research for a specified period and a review of previous research published.

"A finding that a department in an institution had falsified research should be a negative factor when assigning ratings in the research assessment exercise. In this setting justified whistle-blowing would be welcomed by institutions."

As well as describing the problems that he had had in exposing fraudulent research, Dr Wilmshurst also told his audience why some researchers conducted dishonest research in the first place. He listed the following obstacles to honesty:

- Personal ambition for promotion, advancement, money, kudos, and power.
- Those who achieve success by becoming heads of departments or institutions can only maintain their position if their institution continues to succeed. Success is judged largely by the balance sheet. Department heads are expected to pull in research grants.
- The code of silence that pervades the medical profession and the research establishment. There is still considerable reluctance to shop another doctor, no matter how dishonest he or she is.

Dr Wilmshurst described how his own career in medicine had flourished until he tried to get a specialist medical journal to retract a paper, whose results he knew had been falsified. The postgraduate dean of his hospital advised him "to stop upsetting influential people." He was then (the mid-1980s) senior registrar at St Thomas' Hospital, London. "After that for the first time in my career I had difficulty getting a job. I stopped counting the rejections after the 42nd," he said.

A fuller version of Dr Wilmshurst's paper will be published in the next edition of the HealthWatch newsletter. Information can be found at www.healthwatch-uk.org

ROYAL SHREWSBURY HOSPITAL

Peter Wilmshurst: "We need robust checks on research"

Annabel Ferriman *news editor, BMJ*
aferriman@bmj.com

FILM

Demystifying doctors

Two new films probe the doctor-patient relationship

Stormy Weather

Directed by Solveig Anspach

www.lff.org.uk/films_details.php?FilmID=240

Afterlife

Directed by Alison Peebles

For details of future screenings see
www.lff.org.uk/films_details.php?FilmID=8

Rating: ★★★; ★★★

image.net

Stormy Weather shows both doctor and patient as vulnerable

Cinema has rarely tackled the sensitive subject of doctor-patient relationships. While the ethical and behavioural issues about how doctors relate to patients and vice versa have long seemed appropriate stuff for television drama and soap, they do not seem to lend themselves to blockbuster action. However, two films shown at the 47th London Film Festival last week, *Stormy Weather* and *Afterlife*, both sought to examine the fragile interdependence between doctors and patients that is at the heart of medicine.

In *Stormy Weather*, Icelandic director Solveig Anspach explores the close relationship between a psychiatrist, Dora (Élodie Bouchez), and a mysterious, uncommunicative patient, Cora (Didda Jónsdóttir), who is given to sudden and violent tantrums. Dora is intrigued and takes a personal, almost possessive, interest in her patient, spending long hours after work talking about her intimate childhood memories, trying to break through the barrier of silence. When Cora is transferred back to a small isolated island in Iceland, Dora follows her, and a series of traumatic events unfold.

Both doctor and patient are presented as vulnerable human beings who need each other. Most poignantly this is seen, in a reversal of standard roles, when the patient holds the doctor's hand to comfort her. The film suggests that doctors may depend on patients in order to give themselves a sense of purpose, achievement, and fulfilment.

Similarly *Afterlife*, which deals with the subject of euthanasia, raises issues about doctor-patient relationships as well as doctors' accountability to the general public. The main character is an ambitious journalist, Kenny (Kevin McKidd), who is investigating an eminent professor's involvement in a case of euthanasia. While interviewing the professor, Kevin finds him to be torn between his beliefs in patients' rights to decide their own circumstances of death and his own fear of public scrutiny and condemnation.

Kevin's investigation is interrupted when he is summoned back to the family home to look after his sister Roberta (Paula Sage), who has Down's syndrome. The film is positive in its portrayal of Down's syndrome, and Roberta is superbly acted as a funny, humorous, and lovable character. Kevin's mother's general practitioner is presented as a caring doctor, paying home visits and stressing quality of life as an important factor in making treatment decisions.

Afterlife asks serious questions about doctors' responsibilities towards their patients in deciding between different treatment options, and when to withhold or withdraw treatment. Organisations such as the General Medical Council, the Royal College of Nursing, and the BMA have all issued guidelines on withholding treatment and on euthanasia. This film opens these ethical dilemmas to public debate.

Both these films make astute, yet unsentimental observations about the doctor-patient relationship. They help viewers see doctors as human beings as well as professionals—no longer as untouchables in an ivory tower—and as such they are to be welcomed in view of growing public concerns regarding clinical malpractice. There is a need for people to understand doctors' views and limitations—films such as these help to demystify the image of the doctor.

Khalid M Ali *specialist registrar in elderly care, North Staffordshire University Hospital, Stoke-on-Trent*

WEBSITE OF THE WEEK

Injections An article in this week's *BMJ* focuses on the overuse of injections—and unsafe practices in their delivery—in different countries (p 1075). Injections are generally simple procedures learnt in the early years at medical and nursing schools, and a wide range of healthcare professionals can give them. There is little commercial interest in injections, and consequently websites about their appropriate use is scarce.

One site that is worth visiting is that of the Safe Injection Global Network or SIGN (www.injectionsafety.org), which contains important facts about injection practices. SIGN is a voluntary coalition of stakeholders aiming to achieve safe and appropriate use of injections throughout the world. The Blood Safety and Clinical Technology Department of the World Health Organization provides the secretariat for the network. So those interested can find on this site useful information about WHO strategy for the safe and appropriate use of injections worldwide, such as its objectives and interventions at country level (www.who.int/injection_safety/about/en/). There are various resources available to download.

Children are the largest part of the vaccine-receiving population and the Children's Vaccine Program (www.childrensvaccine.org), launched with the support of the Bill and Melinda Gates Foundation, aims to promote equal access to new and lifesaving vaccines worldwide. At http://childrensvaccine.org/html/safe_injection.htm the site offers important information and advice regarding what it calls the "epidemic of unsafe medical injections." There are policy statements and reports, manuals and curriculums on subjects such as the disposal and destruction of syringes and needles and reducing the number of injections given to patients.

Needles penetrating the skin are not only a potential source of infection—they can also arouse extreme phobia. But there is another way. The US Centers for Disease Control and Prevention offers interesting and up to date information on needle free injections (devices, manufacturers, safety, history) at www.cdc.gov/nip/dev/jetinject.htm

Ioana Vlad
BMJ
Clegg scholar
ivlad@bmj.com

PERSONAL VIEW

Failures can be the pillars of success

Few doctors can honestly claim that they have gone through their whole career without failing at something. Even the eminent dean of my medical school when I was sitting finals had allegedly failed his final MB examination because of a love affair with rowing.

Although most of the students botched the odd exam at the end of our first hazy term at medical school, I managed to perform consistently for the whole five years—consistently poorly, that is. Many of my peers never failed again, perhaps being genuinely scared into action by their initial blunders. Whatever the reason, it felt like they were freewheeling while I still needed stabilisers. To add to my bewilderment a handful of students were jettisoned at the end of the first year for failing retakes, many of whom had S levels to their name. Failure, much like illness it seemed, could befall anyone at any time.

As time wore on I became sick of retaking exams. I remember a consultant whom I shadowed in Sussex in my final year saying to me, "Exams? Ah, don't worry about failing a few now and again—we've all done it. It hasn't affected my career at all. Breezing exams doesn't necessarily make you a good doctor." His words offered me only temporary comfort, as I soon went on to "breeze" a fail in the finals, which meant I couldn't take up my post as his house officer. It seemed apocalyptic at the time; in reality it was a chance to take stock.

No one sets out to fail, but in a profession in which some postgraduate examinations have had pass rates as low as 10% to 15% not succeeding is effectively the norm. Last year a friend who had cruised through medical school, gaining distinction in her finals, was unexpectedly trounced by the second part of the MRCP examination—for the third time. Knowing that the odds are stacked against you when you sit this type of exam is of little consolation. If you have never failed an exam before the psychological effects can be immense when you don't make the grade.

Although most doctors' experiences of failure start with exams, the concept of failure extends beyond this. We work in a culture that increasingly calls for accountability and openness. Admitting that we are fallible—that we all make mistakes—is something that has taken years for our profession even to begin to embrace. The concept also applies to meeting our own expectations of ourselves: not getting on a particular rotation, or not getting a paper published in the right journal. It's all relative.

For me, calm reflection and positive thinking have been the key. Getting wound up about failing was depressingly unproductive, especially because deep down I knew why it had happened. (In the early days I had a total lack of aptitude for basic sciences, compared with most students. This resulted in a gross miscalculation in my booze to study ratio, which naturally is different for everyone.)

What I have since found useful is admitting why things went wrong and thinking about what I am going to do to stop it happening again and about whether anything positive can be drawn from it. It's amazing how there are almost always positive outcomes. Cynics would say that I have had to think like this to protect myself from being enveloped by gloom every time I fail. Perhaps there is some truth to this. However, I do know for certain that I would never have spent four extraordinary months abroad, be working in general practice in Buckinghamshire, or have met my wife had I not failed certain exams when I did.

> Experiencing failure has made me more tolerant of colleagues, students, and, most importantly, patients

Apart from improving my problem solving skills and my approach to exams (I don't sit them without good reason), deconstructing mishaps has taught me a lot about myself. I understand better my own strengths and limitations. Experiencing failure has also made me more tolerant of others: colleagues, students, and, most importantly, patients. Being aware of my own fallibility makes it easier to accept shortcomings in others.

I think it is particularly difficult for doctors to handle failure, because the outside world considers us to be highly successful people who have all the answers. It can be difficult to soak up this esteem if there are feelings of disappointment within. Failure has hardened me with its knocks but makes my every success all the more satisfying. I probably haven't seen the last of failure (much as I try to keep it at bay), but should our paths cross again I won't be fazed.

Ultimately, failure is an intrinsic part of the medicine game, common to many competitive professional environments. The best thing we can do is to try to learn from each event and capitalise on it.

Those of you who are yet to experience failure are either supreme beings or perhaps a little lucky; maybe both? As for the rest of us—we're only human.

Ayan Panja *senior registrar in general practice, Aston Clinton, Buckinghamshire*
ayanpanja@hotmail.com

SOUNDINGS

Who cleans the clogs?

Surgeons have an image of being control freaks, but today's operating theatres are more democratic than you think. Few of us surgeons enjoy sitting in a circle and sharing our thoughts in an egalitarian way, but then nor do the rest of the team. Each member—nurse, technician, anaesthetist—is proud of his or her role and knows that the rest do not fully understand it.

Nevertheless, most decisions are shared. Patient and surgeon together decide whether an operation is needed. Others in the NHS determine whether it goes ahead and when it can start. Almost the only decision left to the surgeon is to say when it is finished.

How the operation is done is increasingly determined by distant bodies. Centralised packs contain standard instruments. More and more items are disposable. Curiously shaped plastic devices appear, presumably to protect patient or staff. You learn not to ask about the evidence base for these changes. Rules are rules—they have been made by someone else's professional body or by an important sounding committee. Clinical governance means unquestioning obedience.

Despite all the bureaucracy, you feel that nobody is really in charge. When you are called to an unfamiliar theatre the technicians address you as "mate." On home ground your team may consist of a nurse from an agency, a locum registrar (European working hours, you know), and whichever senior house officer is on that shift. All anonymous in theatre "blues." Symbols of rank would be discriminatory.

In the changing rooms are bloodstained clogs. It is the same throughout the country, according to an informal survey of colleagues. A distant body has decreed that everyone now cleans their own. Unenforceable, particularly in large operating suites, but hey, it's democratic.

My first job in hospital, as a student clerk in 1968, was cleaning the surgeons' boots. I was supervised by the chief orderly, a former soldier. Clean boots symbolised a well run army and we were proud that our surgeons could expect the same when they entered our theatre.

Why does the passing of this tradition upset me so much? I should be grateful that I am now paid a six figure salary to clean my own boots. And that nobody expects me to care about the others. Not your job, mate.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*